KYOWA KIRIN cares
ACCESS • ASSISTANCE • UNDERSTANDING

Kyowa Kirin Cares Prescription & Enrollment Form

| Phone: 833-KK-CARES | Fax: 844-267-5848 | M-F, 8AM to 8PM EST |

Support Requested for this Patient

☐ Reimbursement Assistant- Physician willl Buy and Bill ☐ Reimbursement Assistant- Fill Through Specialty Pharmacy ☐ Copay Assistance

Patient Information

First Name: _____ Last Name: _____ DOB: ___/___/___

Address: _____ City: _____

State: _____ ZIP: _____ SSN: ___ – ___ – ___ US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female

Cell Phone: (___) _____ Home Phone: (___) _____ Email: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Email Best Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Patient Insurance Information – *Please attach copies of cards for both primary and secondary insurance plans* –

Medical Insurance Name: _____ Phone: (___) _____

Pharmacy Insurance Name: _____ Phone: (___) _____

Medical Plan ID #: _____ Policy Holder Name & DOB: _____

Group #: _____ Rx BIN: _____ Rx PCN: _____ Secondary Plan? ☐ Yes ☐ No

Plan Type: ☐ Private / Commercial ☐ Medicare Part D ☐ Medicare Advantage ☐ Medicaid ☐ VA or Military ☐ None- Uninsured

Prescriber Information

Physician Name: _____ Physician NPI #: _____

Facility Name: _____ Group Tax ID#: _____

Address: _____ City: _____

State: _____ ZIP: _____ Phone #: (___) _____ Fax #: (___) _____

Office Contact Name: _____ Contact Email Address: _____

Clinical Information

Primary Diagnosis Code (ICD-10): _____ Primary Diagnosis Description:

Allergies: _____

Prescription for POTELIGEO® (mogamulizumab-kpkc)

Rx: POTELIGEO (mogamulizumab-kpkc) – 20mg per 5mL Patient Weight: _____ kg Refills: _____

☐ Initiating Therapy – 1mg/kg IV QW for the first 5 infusions ☐ Maintenance – 1mg/kg IV QOW ☐ Other *(write in below)*

Rx Notes: _____

I certify that the information in this Prescription & Enrollment Form is complete and accurate to the best of my knowledge. By signing this Prescription & Enrollment Form* I certify that I have prescribed POTELIGEO (mogamulizumab-kpkc) based on my professional judgment of medical necessity, and that I will supervise the patient's medical treatment. I authorize the release of medical and/or other patient information relating to POTELIGEO therapy to agents, and service providers of Kyowa Kirin (including but not limited to Sonexus Health LLC and POTELIGEO-dispensing pharmacies) to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient for the purpose of verifying benefit eligibility and obtaining coverage authorization.

Prescriber Signature: _____ Date: _____

*Original signature is required – *If required by applicable law, please attach copies of all prescriptions on official state prescription forms*

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Patient Authorization

By signing this Authorization, I authorize each of my physicians, pharmacists, including any specialty pharmacy that receives my prescription for POTELIGEO (mogamulizumab-kpkc) and other healthcare providers (together "Healthcare Providers") and each of my health insurers (together, "Insurers") to disclose my Protected Health Information, including but not limited to medical records, information related to my medical condition and treatment, my health insurance coverage, my name, address, telephone number, Social Security number, insurance plan and or group numbers (together, "Protected Health Information") to Kyowa Kirin, its affiliated companies, vendors, agents, collaboration partners, and representatives (together, "Kyowa Kirin") including providers of alternate sources of funding for prescription drug costs, and other service providers supporting Kyowa Kirin Cares Support Services (the "Program") for Healthcare Providers and patients for the purposes described below.

Specifically, I authorize disclosure of my Protected Health Information in order to:

I. Enroll me in, and contact me about the Program, including online support, financial assistance services, co-pay assistance, nurse services, and compliance and persistency services,
II. Communicate with my Healthcare Providers and Insurers about benefits, coverage and medical care, including compliance with Product treatments,
III. Locate a specialty pharmacy that can fill my prescription and facilitate dispensing of my prescription by such pharmacy,
IV. Provide me with educational materials, information and services related to my treatment experience with POTELIGEO and my condition,
V. Contact me and leave messages about my use of POTELIGEO and my medical care,
VI. Verify, investigate, assist with, and coordinate my coverage for POTELIGEO with my Insurers,
VII. Coordinate prescription fulfillment,
VIII. Conduct surveys, data analytics, market research and other internal business activities related to the Program, POTELIGEO, and other Kyowa Kirin products and programs, and
IX. Contact me as otherwise required or permitted by law.

I understand that pharmacies that ship my medication may be paid to share this information with the Program to help provide the offerings requested for me. Once my Protected Health Information has been disclosed to Kyowa Kirin, I understand that federal privacy laws no longer protect the information. However, Kyowa Kirin agrees to protect my Protected Health Information by using and disclosing it only for the purposes described in this authorization or as permitted by law.

I understand that I may refuse to sign this Authorization. My choice about whether to sign will not change the way my Healthcare Providers or Insurers treat me, but I will not have access to the Program and the services provided by Kyowa Kirin under the Program. If I refuse to sign the Authorization, or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from the Program.

This Authorization will last for a period of five (5) years (unless earlier termination is required by applicable state law). I understand that I may cancel this Authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by mailing a request to 2730 S. Edmonds Lane, Suite 300 Lewisville, TX 75067, via fax at 844-267-5848, or by calling 833-552-2737. I understand that revoking this Authorization will end further uses and disclosure of my Protected Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization as permitted by applicable law. I am entitled to receive a copy of this Authorization.

The personal and health insurance I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this Form changes by contacting the Program at 833-552-2737.

Name of Patient: _____ Signature: _____ Date: _____
Please Print

Patient Authorized Representative

I permit Kyowa Kirin Cares Support Services representatives to speak with the following person about this enrollment form. This includes discussing the status of my application, insurance and financial questions, any missing documentation and other issues related to my enrollment, insurance appeals, or any other treatment related issues. I may cancel this authorization at any time by calling: 833-552-2737.

Name of Authorized Representative: _____ Relationship to Patient: _____

Telephone Number: ( ) _____ Email: _____

By signing below, I, the patient named above, allow this representative to speak on my behalf on any matter regarding my enrollment with the Program.

Signature: _____ Date: _____